

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030362

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318 XC-113778, SL-3119

Primary Registration District No.

1003 7595

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 1 1963

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis, Missouri

Length of stay in lb

15 days

c. FULL NAME OF (If NOT in hospital, give location)

VA Hospital, St. Louis

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MISSOURI

b. COUNTY

St. Louis

c. CITY

Scott City, Missouri

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS

Box 313

Reside on Farm

Yes ☒ No ☐

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

GEORGE

M

PALMER

4. DATE OF DEATH

Month

Day

Year

7-23-63

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH

11-17-94

9. AGE (last birthday)

68

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Nebraska City, Nebr.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Jesse M. Palmer

13b. MOTHER'S MAIDEN NAME

Margaret Hallagan

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes 9-17-17 to 12-4-18

16. SOCIAL SECURITY NO.

James E. Palmer (Son)

17. INFORMANT Address

1109 R. Merrimathe Cape Girardeau

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c) 4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month; Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. Attended the deceased from 7-8-63 to 7-23-63 and last saw him alive on 7-23-63

Death occurred at 11:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

George H. Foraker

M.D.

22b. ADDRESS

VAH, ST. LOUIS, MO

22c. DATE SIGNED

7-23-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

7/27/63

23c. NAME OF CEMETERY OR CREMATORY

Local

23d. LOCATION (City, town, or county)

CAPE GIRARDEAU

(State)

MO

24. FUNERAL DIRECTOR

HAMAN

ADDRESS

CAPE GIRARDEAU MO

25. DATE RECD. BY LOCAL REG.

JUL 24 1963

26. REGISTRAR'S SIGNATURE

Lois Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Frank Prokop

Licensed Embalmer No.

4352

P. O. Address

St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.